CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 517 **Date: APRIL 1, 2005**

CHANGE REQUEST 3747

SUBJECT: List of Medicare Telehealth Services

I. SUMMARY OF CHANGES: In the final 2005 physicians fee schedule rule, CMS added HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 to the list of Medicare telehealth services. To manualize this rule, chapter 12, sections 190.3, 190.6.1 and 190.7 have been revised.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2005
IMPLEMENTATION DATE: May 2, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	12/190.3/ List of Medicare Telehealth Services
R	12/190.6.1/ Submission of Telehealth Claims for Distant Site Practitioners
R	12/190.7/ Carrier Editing of Telehealth Claims

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 517	Date: April 1, 2005	Change Request 3747

SUBJECT: List of Medicare Telehealth Services

I. GENERAL INFORMATION

A. Background: In the final physician fee schedule rule published November 7, 2003 (68 FR 63216), CMS established new G codes for managing patients on dialysis with payments varying based on the number of visits provided within each month. Under this methodology, separate codes are billed for providing 1 visit per month, 2-3 visits per month, and 4 or more visits per month. The lowest payment amount applies when a physician provides 1 visit per month; a higher payment is provided for 2 to 3 visits per month. To receive the highest payment amount, a physician would have to provide at least 4 ESRD-related visits per month. The G codes require a complete monthly assessment of the beneficiary, including the establishment of a monthly care plan and are reported once per month for services performed in an outpatient setting that are related to the patients' ESRD.

As part of CMS' process for adding services to the list of Medicare telehealth services, the nephrology community expressed concerns that CMS' change in payments for managing patients on dialysis results in hardships for rural and isolated areas, especially in frontier areas where physicians would be forced to make multiple long-distance trips during a month to see their patients or vice versa. To address this issue, CMS added ESRD-related services included in the monthly capitation payment (MCP) to the list of Medicare telehealth services in the physician fee schedule final rule published November 15, 2004 (69 FR 66276).

However, CMS specified that 1 visit per month must be furnished face-to- face "hands on" to examine the vascular access site. Moreover, CMS clarified that only the facilities, as authorized by section 1834(m) of the Act may serve as a Medicare telehealth-originating site. Prior to this change request, the list of Medicare telehealth services included office and other outpatient visits, consultation, individual psychotherapy, pharmacologic management and the psychiatric diagnostic interview examination (as described by CPT codes 99201-99215, 99241-99275, 90804-90809, 90862, and 90801).

B. Policy: The list of Medicare telehealth services has been expanded to include ESRD-related services as described by HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318. Effective January 1, 2005, the telehealth modifiers "GT" (via interactive audio and video telecommunications system) and modifier "GQ" (via asynchronous telecommunications system) are valid when billed with these ESRD-related service HCPCS codes. This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in Pub. 100-02, chapter 15, section 270 and Pub. 100-04, chapter 12, section 190. For example, originating sites only include a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or Federally qualified health center. Originating sites must be located in either a non-MSA county or rural health professional shortage area. An interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit. The only

exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used. For more information on Medicare telehealth payment policy and claims processing instructions see Pub. 100-02, chapter 15, section 270 and Pub. 100-04, chapter 12, section 190.

In order to bill for ESRD-related services under the MCP as a telehealth service, at least 1 visit per month must be furnished face-to-face (not as telehealth) to examine the vascular access site. The clinical examination of the vascular access site must be furnished face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner, or physicians assistant. Additional visits under the MCP may be furnished via an interactive telecommunications system.

By using the telehealth services modifier e.g., G0318 GT, the MCP physician or practitioner attests that a clinical examination of the vascular access site was furnished face-to-face "hands on" by a physician clinical nurse specialist, nurse practitioner, or physician's assistant. The medical record should include sufficient documentation that the complete assessment of the ESRD beneficiary including a clinical examination of the vascular access site was furnished face-to-face.

The Medicare beneficiary must be located in an originating site at the time the telehealth service is furnished. Medicare telehealth originating sites only include a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or Federally qualified health center. ESRD facilities are not originating sites (dialysis facilities are not defined in the law as an originate site). ESRD-related visits may be furnished through an interactive telecommunications system (other than the required visit to examine the vascular access site) when the beneficiary is located in an originating site as defined in Pub. 100-02, chapter 15, section 270.1 (including a physician's satellite office within a dialysis center).

Clarification for originating sites billing for the telehealth originating site facility fee.

With regard to ESRD-related services included in the MCP, the originating site facility fee payment may be made for each visit furnished through an interactive telecommunications system. When the physician or practitioner at the distant site furnishes an ESRD-related patient visit included in the MCP through an interactive telecommunications system, the originating site may bill for a telehealth facility fee.

Example: A 70 year old ESRD beneficiary receives 2 ESRD-related visits through an interactive telecommunications system and the required face-to-face visit (to examine the vascular access site) during the month of November. In this scenario the originating site should bill for two originating site facility fees as described by HCPCS code Q3014 and the MCP physician at the distant site should bill for ESRD-related services with 2 to 3 visits as a telehealth service, e.g., G3018 GT.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3747.1	Effective January 1, 2005, local part B Carriers shall pay for HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier.			X						
3747.2	Contractors do not have to search their files and reprocess claims for HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 with dates of service on or after January 1, 2005. However, contractors shall adjust any claims for these services that are brought to their attention.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3747.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into your outreach activities, as appropriate. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** May 2, 2005 **Pre-Implementation Contact(s):** Policy: Craig Dobyski (410) 786-4584; Cdobyski@cms.hhs.gov Part B Claims Processing: Kathy Kersell (410) 786-2033; KKersell@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

190.3 - List of Medicare Telehealth Services

(Rev. 517, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, and pharmacologic management. These services and corresponding current procedure terminology (CPT) codes are listed below.

- Consultations (CPT codes 99241 - 99275);
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862); and
- Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003.
- *End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) – Effective January 1, 2005.*

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners

(Rev. 517, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

Claims for professional consultations, office visits, individual psychotherapy, and pharmacologic management provided via a telecommunications system are submitted to the carrier that processes claims for the performing physician/practitioner's service area. Physicians/practitioners submit the appropriate CPT procedure code for covered professional telehealth services along with the "GT" modifier ("via interactive audio and video telecommunications system"). By coding and billing the "GT" modifier with a covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. *Also, by coding and billing the "GT" modifier with a covered ESRD-related service telehealth code (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318), the distant site physician/practitioner certifies that 1 visit per month was furnished face-to-face "hands on" to examine the vascular access site. Refer to Pub. 100-02, Chapter 15, Section 270.4.1 for the coverage policy.*

To claim the facility payment, physicians/practitioners will bill HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." For carrier-processed claims, the "office" place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014 and it is not priced off of the MPFS Database file. Deductible and coinsurance rules apply to Q3014. By submitting HCPCS code "Q3014," the biller certifies that the originating site is located in either a rural HPSA or a non-MSA county.

Physicians and practitioners at the distant site bill their local Medicare carrier for covered telehealth services, for example, "99245 GT." Physicians' and practitioners' offices serving as a telehealth originating site bill their local Medicare carrier for the originating site facility fee.

190.7 - Carrier Editing of Telehealth Claims

(Rev. 517, Issued: 04-01-05; Effective: 01-01-05; Implementation: 05-02-05)

Effective October 1, 2001, covered telehealth services include CPT codes 99241 – 99275, 99201 – 99215, 90801 (effective March 1, 2003), 90804 - 90809, and 90862. *Effective January 1, 2005, covered telehealth services also include HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318.* When furnished as telehealth services these codes are billed with either the "GT" or "GQ" modifier.

The carrier shall approve covered telehealth services if the physician or practitioner is licensed under State law to provide the service. Carriers must familiarize themselves with licensure provisions of States for which they process claims and disallow telehealth services furnished by physicians or practitioners who are not authorized to furnish the applicable telehealth service under State law. For example, if a nurse practitioner is not licensed to provide individual psychotherapy under State law, he or she would not be permitted to receive payment for individual psychotherapy under Medicare. The carrier shall install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services.

If a carrier receives claims for professional telehealth services coded with the "GQ" modifier (representing "via asynchronous telecommunications system"), it shall approve/pay for these services only if the physician or practitioner is affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii. The carrier may require the physician or practitioner at the distant site to document his or her participation in a Federal telemedicine demonstration program conducted in Alaska or Hawaii prior to paying for telehealth services provided via asynchronous, store and forward technologies.

If a carrier denies telehealth services because the physician or practitioner may not bill for them, the carrier uses MSN message 21.18: "This item or service is not covered when performed or ordered by this practitioner." The carrier uses remittance advice message *52* when denying the claim based upon MSN message 21.18.

If a service is billed with one of the telehealth modifiers and the procedure code is not designated as a covered telehealth service, the carrier denies the service using MSN message 9.4: "This item or service was denied because information required to make payment was incorrect." The remittance advice message depends on what is incorrect, e.g., B18 if procedure code or modifier is incorrect, 125 for submission billing errors, 4-12 for difference inconsistencies. The carrier uses B18 as the explanation for the denial of the claim.